Application for Health Coverage

maryland health connection℠

THINGS TO KNOW

Who can use this application?

Anyone who needs health coverage can use this application.

If someone is helping you fill out this application, you may need to complete Appendix C.

Apply faster online

Apply faster online at MarylandHealthConnection.gov.

What happens next?

Send your complete, signed application to the address on page 3.
(If you don't have all the information we ask for, sign and submit your application anyway.)

We'll follow up with you within 1–2 weeks to let you know how to join a health plan.

Filling out this application doesn't mean you have to buy health coverage.

Get help with costs

You need to use a different application to get help with costs. You could qualify for:

- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost coverage from Medicaid or the Maryland Children's Health Program (MCHP)

You may qualify for a free or low-cost program even if you earn as much as $94,000 a year (for a family of 4).
Visit MarylandHealthConnection.gov or call 1-855-642-8572 to learn more.

Get help with this application

- **Online:** MarylandHealthConnection.gov.
- **Phone:** Call our consumer support center at **1-855-642-8572.**
- **In person:** There may be counselors in your area who can help. Visit MarylandHealthConnection.gov or call **1-855-642-8572** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-855-642-8572.**

NEED HELP WITH YOUR APPLICATION? Visit MarylandHealthConnection.gov or call us at **1-855-642-8572**. Para obtener una copia de este formulario en Español, llame **1-855-642-8572**. If you need help in a language other than English, call **1-855-642-8572** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-642-8573**.

MHC10091113C

STEP 1 Tell us about yourself.

(We'll need one adult in the family to be the contact person for your application.)

1. First name, Middle name, Last name, & Suffix

2. Home address (Leave blank if you don't have one.) | 3. Apartment or suite number

4. City | 5. State | 6. ZIP code | 7. County

8. Mailing address (if different from home address) | 9. Apartment or suite number

10. City | 11. State | 12. ZIP code | 13. County

14. Phone number ( ) –

15. Other phone number ( ) –

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken or written language (if not English)?

18. Do you need health coverage?
☐ Yes. **If yes**, answer all the questions below.
☐ No. **If no**, skip to Step 2 on page 2. (Leave the rest of this page blank)

19. Social Security number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

We need Social Security Numbers (SSNs) for anyone who wants coverage. We use SSNs to verify citizenship. If someone doesn't have an SSN, visit socialsecurity.gov or call 1-800-772-1213. TTY users should call 1-800-325-0778.

20. Sex ☐ Male ☐ Female

21. Date of birth (mm/dd/yyyy)

22. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

23. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status?
☐ Yes. Fill in your document type and ID number below.

Immigration document type _____ Document ID number _____

24. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

25. **Race (OPTIONAL—check all that apply.)**

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

NOW, tell us who else needs health coverage.

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STEP 2 Tell us about anyone who needs health coverage.

STEP 2: PERSON 2

(If you have more people to include, make a copy of this page and attach.)

1. First name, Middle name, Last name, & Suffix

2. Relationship to you?

3. Social Security number
___ ___ ___ - ___ ___ - ___ ___ ___ ___

4. Date of birth (mm/dd/yyyy)

5. Sex ☐ Male ☐ Female

6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No **If no**, list address:

7. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No

8. **If PERSON 2 isn't a U.S. citizen or U.S. national**, do they have eligible immigration status?

☐ Yes. Fill in PERSON 2's document type and ID number below:

Immigration document type _____ Document ID number _____

9. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

10. **Race (OPTIONAL—check all that apply.)**

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other _____

STEP 2: PERSON 3

1. First name, Middle name, Last name, & Suffix

2. Relationship to you?

3. Social Security number
___ ___ ___ - ___ ___ - ___ ___ ___ ___

4. Date of birth (mm/dd/yyyy)

5. Sex ☐ Male ☐ Female

6. Does PERSON 3 live at the same address as you? ☐ Yes ☐ No **If no**, list address:

7. Is PERSON 3 a U.S. citizen or U.S. national? ☐ Yes ☐ No

8. **If PERSON 3 isn't a U.S. citizen or U.S. national**, do they have eligible immigration status?

☐ Yes. Fill in PERSON 3's document type and ID number below:

Immigration document type _____ Document ID number _____

9. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

10. **Race (OPTIONAL—check all that apply.)**

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other _____

STEP 2: PERSON 4

1. First name, Middle name, Last name, & Suffix

2. Relationship to you?

3. Social Security number
___ ___ ___ - ___ ___ - ___ ___ ___ ___

4. Date of birth (mm/dd/yyyy)

5. Sex ☐ Male ☐ Female

6. Does PERSON 4 live at the same address as you? ☐ Yes ☐ No **If no**, list address:

7. Is PERSON 4 a U.S. citizen or U.S. national? ☐ Yes ☐ No

8. **If PERSON 4 isn't a U.S. citizen or U.S. national**, do they have eligible immigration status?

☐ Yes. Fill in PERSON 4's document type and ID number below:

Immigration document type _____ Document ID number _____

9. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

10. **Race (OPTIONAL—check all that apply.)**

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
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☐ Other Pacific Islander
☐ Other _____

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STEP 3 American Indian or Alaska Native (AI/AN) family member(s)

1. **Are you or is anyone in your family American Indian or Alaska Native?**

☐ **No. If no,** skip to Step 4.

☐ **Yes. If yes,** continue. If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
2. Name (First name, Middle name, Last name)	First Middle	First Middle
	Last	Last
3. Member of a federally recognized tribe?	☐ Yes **If yes**, tribe name _____ ☐ No	☐ Yes **If yes**, tribe name _____ ☐ No

STEP 4 Read & sign this application.

- I'm signing this application under penalty of perjury, which means I've provided true answers to all of the questions to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.
- I know that I must tell Maryland Health Connection if anything changes (and is different than) what I wrote on this application. I can visit MarylandHealthConnection.gov or call **1-855-642-8572** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I know that my information on this form will only be used to determine eligibility for health coverage and will be kept private as required by law.
- I confirm that no one applying for health coverage on this application is incarcerated (detained or jailed). If not, _____ incarcerated.
  (name of person)
- I understand that my information will be used to check eligibility for health coverage. We'll check your answers using information in our electronic databases and databases from Social Security and the Department of Homeland Security. If the information doesn't match, we may ask you to send us proof.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative, you may sign here as long as you have provided the information required in Appendix C.

Signature	Date (mm/dd/yyyy)

STEP 5 Mail completed application.

Mail your signed application to:

Maryland Health Connection
P.O. Box 857
Lanham, MD 20703-0857

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